

provide notice to the Department of Health and Human Services. This requirement is satisfied if the plan or issuer sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (g)(6)(ii)(A) of this section identifying the benefit package to which the exemption applies.

(iii) *Confidentiality.* A notification to the Secretary under this paragraph (g)(6) shall be confidential. The Secretary shall make available, upon request and not more than on an annual basis, an anonymous itemization of each notification that includes—

(A) A breakdown of States by the size and type of employers submitting such notification; and

(B) A summary of the data received under paragraph (g)(6)(ii) of this section.

(iv) *Audits.* The Secretary may audit the books and records of a group health plan or a health insurance issuer relating to an exemption, including any actuarial reports, during the 6 year period following notification of such exemption under paragraph (g)(6) of this section. A State agency receiving a notification under paragraph (g)(6) of this section may also conduct such an audit with respect to an exemption covered by such notification.

(h) *Sale of nonparity health insurance coverage.* A health insurance issuer may not sell a policy, certificate, or contract of insurance that fails to comply with paragraph (b) or (c) of this section, except to a plan for a year for which the plan is exempt from the requirements of this section because the plan meets the requirements of paragraph (f) or (g) of this section.

(i) *Applicability dates—(1) In general.* Except as provided in paragraph (i)(2) of this section, this section applies to group health plans and health insurance issuers offering group health insurance coverage on the first day of the first plan year beginning on or after July 1, 2014. Until the applicability date, plans and issuers are required to continue to comply with the corresponding sections of §146.136 contained in the 45 CFR, parts 1 to 199, edition revised as of October 1, 2013.

(2) *Special effective date for certain collectively-bargained plans.* For a group

health plan maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the requirements of this section do not apply to the plan (or health insurance coverage offered in connection with the plan) for plan years beginning before the date on which the last of the collective bargaining agreements terminates (determined without regard to any extension agreed to after October 3, 2008).

[78 FR 68286, Nov. 13, 2013]

Subpart D—Preemption and Special Rules

§ 146.143 Preemption; State flexibility; construction.

(a) *Continued applicability of State law with respect to health insurance issuers.* Subject to paragraph (b) of this section and except as provided in paragraph (c) of this section, part A of title XXVII of the PHS Act is not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(b) *Continued preemption with respect to group health plans.* Nothing in part A of title XXVII of the PHS Act affects or modifies the provisions of section 514 of ERISA with respect to group health plans.

(c) *Special rules—(1) In general.* Subject to paragraph (c)(2) of this section, the provisions of part A of title XXVII of the PHS Act relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 2701 of the PHS Act which differs from the standards or requirements specified in section 2701 of the PHS Act.

(2) *Exceptions.* Only in relation to health insurance coverage offered by a health insurance issuer, the provisions

§ 146.145

of this part do not supersede any provision of State law to the extent that such provision requires special enrollment periods in addition to those required under section 2702 of the Act.

(d) *Definitions*—(1) *State law*. For purposes of this section the term *State law* includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia is treated as a State law rather than a law of the United States.

(2) *State*. For purposes of this section the term *State* includes a State (as defined in § 144.103), any political subdivisions of a State, or any agency or instrumentality of either.

[69 FR 78797, Dec. 30, 2004; 70 FR 21147, Apr. 25, 2005; 79 FR 10315, Feb. 24, 2014]

§ 146.145 Special rules relating to group health plans.

(a) *Group health plan*—(1) *Definition*. A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) *Determination of number of plans*. [Reserved]

(b) *Excepted benefits*—(1) *In general*. The requirements of subparts B and C of this part do not apply to any group health plan (or any group health insurance coverage) in relation to its provision of the benefits described in paragraph (b) (2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances*. The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general*. Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (b)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (b)(3)(v) of this section.

(ii) *Not an integral part of a group health plan*. For purposes of this paragraph (b)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if the following two requirements are satisfied—

(A) Participants must have the right to elect not to receive coverage for the benefits; and

(B) If a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage.

(iii) *Limited scope*—(A) *Dental benefits*. Limited scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth).

(B) *Vision benefits*. Limited scope vision benefits are benefits substantially all of which are for treatment of the eye.

(iv) *Long-term care*. Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care services, as defined in section 7702B(c)(1) of the Internal Revenue Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Internal Revenue Code; or

45 CFR Subtitle A (10–1–14 Edition)